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UNDERSTANDING THE RELATIONSHIP BETWEEN
COMPASSION AND EMPLOYEE ENGAGEMENT

A Research Project
Presented to the Faculty of
The George L. Graziadio
School of Business and Management
Pepperdine University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
in
Organization Development

by
Dana Shapiro Lenz

August 2017

This research project, completed by

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Under the guidance of the Faculty Committee and approved by its members, has been submitted to and accepted by the faculty of The George L. Graziadio School of Business and Management in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE
IN ORGANIZATION DEVELOPMENT

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Abstract

Both compassion and employee engagement are determined to have positive impacts in a healthcare setting. Previous research indicates that patients who receive compassionate care from healthcare providers may recover more quickly from illnesses and better manage long-term health issues. Additionally, high employee engagement has been shown to have a positive relationship with quality of patient care, patient safety, and patient-centered care. Due to the far-reaching impact of both variables, an association between compassion and employee engagement would enable healthcare providers to leverage the relationship for improved patient outcomes.

This study explored the relationship between compassion and employee engagement. Qualitative data was collected from 118 nurses through the International Nurses Society on Addictions. All participants completed a 9-item Utrecht Work Engagement Scale (UWES). Participants were then distributed by engagement category and volunteers were contacted to complete a semi-structured interview to discuss their experiences with compassion in the workplace. This qualitative data was obtained from nine interviewees.

A review of the research data and previous academic research led to four findings. First, previous academic research findings were confirmed. Second, the participant's connection to compassion in their work indicated the importance of this emotionally charged topic. Third, a trend between the average frequency of daily acts of compassion and engagement level indicated a potential relationship or confounding variable. Fourth, the research data indicated an inconclusive relationship between compassion and employee engagement.

Keywords: Engagement, Compassion, Nursing

Acknowledgements

To the nurses who participated in this research: thank you for making this possible. Thank you for sharing your incredible stories with me. With this research, I have tried to bring light to the important work that you do. The compassion and love you give to your patients is an inspiration.

Thank you to my thesis advisor, Gary Mangiofico, and the Pepperdine faculty for providing encouragement, guidance, and support. You make learning come to life and it has been a joy to get to know you and learn from you.

An enormous thank you to my family. Thank you to my parents, Amy and Mitch Shapiro, for supporting me every step of the way and reminding me to enjoy the journey. Thank you to my sister, Kate Flaxman, for teaching me endless lessons about life, friendship, and forgiveness. Thank you to my grandmother, Joan Newman, one of my first teachers who instilled the value of education and the belief that I could accomplish anything to which I set my mind and heart.

To my husband, Robin Lenz, thank you for standing by my side through this journey. Thank you for being my editor, my motivator, and the other half of my think tank. Your passion for medicine and the compassion you show your patients were the inspiration for this thesis. Thank you for sharing your life with me.

Once upon a time, an old man used to go to the ocean to walk along the beach. Early one morning after a big storm, he found the beach littered with starfish.

The old man noticed a small boy approaching. As the boy walked, he paused every so often and bent down to pick up an object and throw it into the sea. The man called out, "Good morning! May I ask what it is that you are doing?"

The boy looked up and said "Throwing starfish into the ocean. The tide has washed them up onto the beach and they can't return to the sea by themselves. When the sun gets high, they will die, unless I throw them back into the water."

The old man replied, "But there must be tens of thousands of starfish on this beach. I'm afraid you won't really be able to make much of a difference."

The boy bent down, picked up yet another starfish and threw it as far as he could into the ocean. Then he turned, smiled and said, "It made a difference to that one."

- Recited by an interviewee & adapted from The Star Thrower (Eiseley, 1979)

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Chapter 1

Medical facilities provide many things to many people. For patients, they are a place to heal physically and mentally. They are a place of safety and care. At the same time, medical facilities are a place of work for many. Physicians, nurses, technicians, administrators, and others report to these workplaces each day and have a completely different experience. Healthcare professionals choose their work for many different reasons: finding meaning in helping others, a paycheck, love of medicine, and more.

It is at the intersection of these experiences that compassion can exist. In an environment where emotions run high and distress is frequently part of the day, how can medical professionals provide what patients and families need, while also fulfilling their own needs? In this situation, compassion is key.

Compassion enables a physician to connect with a sick patient or a family member in need of help. Compassion enables a nurse to build a relationship with another nurse, providing emotional support during a long day of work. Compassion builds communities of support and care that enable healthcare providers to share in suffering and grief when needed.

Significance of Study

The healthcare system in the United States is under heavy strain and scrutiny. Medical facilities are constantly strapped to do more with less, dealing with challenges that impact patient care, employee satisfaction, and the bottom line financials. Healthcare costs in the United States are higher than other high-income countries yet yield lower quality results (Squires, 2015). Compared to these countries, America is challenged with lower life expectancy rates and higher infant mortality rates. Americans spend more on drugs and diagnostic imaging. Lastly, the United States spends the smallest share of healthcare dollars on social services.

With these challenges and more, money is being directed to healthcare in the United States to fix a broken system. To spur a systematic approach to change and optimize health system performance in the United States, the Institute for Healthcare Improvement (IHI) has created the Triple Aim Initiative (IHI Triple Aim, 2016). The Triple Aim Initiative includes three dimensions: 1) improving the patient experience of care, 2) improving the health of populations, and 3) reducing the per capita cost of healthcare.

The Triple Aim strives to incite improvements within the healthcare system, focusing on five key areas: 1) providing information and therefore choice to patients, 2) redesigning “primary care” to create better access, 3) aligning practices around prevention and promotion of health, 4) reducing costs, and 5) integrating elements of the Triple Aim system to enable individuals to receive the services they need (The IHI Triple Aim, 2016).

The Triple Aim is one initiative gaining traction in spurring change in healthcare. The framework is currently being tested in the United States and internationally, with health plans, hospitals, military, and others. But what if one factor that can have a big impact on the system is free and waiting to be tapped?

Employee engagement is shown to have significant positive impacts on organizations by enabling higher quality at a lower cost (Berry & Morris, 2008). High levels of employee engagement in organizations lead to improved employee satisfaction and decreased turnover rates (Berry & Morris, 2008). Medical facilities also experience these positive impacts, as well as benefits pertaining to improved patient care and patient safety. Improved retention creates a powerful impact for medical facilities as it relates to patient care, even significantly impacting patient mortality rates and length of patient stay. Increased employee engagement also impacts

patient safety by increasing compliance for safety behaviors, including hand-hygiene (Studer, Hagins, & Cochrane, 2014).

With these positive implications and more, it is no surprise that employee engagement has the power to impact healthcare financials. Dollars saved from a decrease in healthcare associated infections, decrease in patient falls, and decrease in employee turnover all add up. A focus on employee engagement can lead to positive impacts in all areas.

It is with employee engagement in mind that we turn back to compassion. Acting compassionately, towards colleagues and patients, creates an opportunity to connect with another at a time when they need it most. In a moment where the suffering of another is witnessed, it takes the same amount of time and energy to show compassion as it does to disregard their distress. A culture of compassion in a medical facility, where healthcare providers are allowed and even encouraged to care for others in this way, creates an environment where employee engagement can flourish. The Charter for Compassion describes its partnership with Compassion in Healthcare (2015):

“A compassionate healthcare system provides holistic care that recognizes the immense importance of healing relationships, and pays attention not only to physical disease and bio-medicine but also to emotional, psychological, social and spiritual wellbeing of patients and their families. Attending to compassion and relationships in healthcare significantly improves quality, outcomes, satisfaction, and experience of care” (para. 2).

Consider this scenario: A patient who is addicted to drugs comes into a treatment center. The nurse has options. She can put him in a room and leave, coming back a few hours later to check on him. Alternatively, and in an environment where compassion is the norm, the nurse may seize this moment to welcome the patient to the treatment center, ask if he needs anything, and listen to the patient if he wants to talk.

In a culture of compassion, taking care of others to ease their suffering comes easily. In the context of describing compassion in their work with elderly patients suffering from chronic disease, nurses defined compassion in seven dimensions: attentiveness, listening, confronting, involvement, helping, presence, and understanding (van der Cingel, 2011). These compassionate gestures, no matter how small, have the power to snowball into something greater.

As in the scenario above, showing compassion is one action that can not only better aid the patient, but also affect the healthcare provider at the same time. Spending the time to connect with the patient and providing a positive experience has the ability to save the healthcare system thousands of dollars later by preventing later medical visits and relapses. At the same time, creating an environment for a nurse to act compassionately may also impact the nurse's feelings toward their job and the work they are doing. The gratitude from a patient who was able to get sober for the first time can have a lasting impact on the employee engagement of a healthcare provider, and that is where compassion has the power to grow into something greater. Luckily, the opportunities for compassion in medicine are boundless.

Compassion also has benefits when expressed between colleagues. Workplaces with higher levels of expressed compassion between colleagues experience lower levels of absenteeism and employee burnout, as well as increased teamwork and employee satisfaction that lead to higher levels of employee engagement ("Why Fostering", 2014). These benefits can create a powerful environment that perpetuates compassion in everyday interactions. Fostering a culture of compassion in all aspects of a medical facility, from patient interactions to the team environment, can lead to significant benefits for everyone involved.

Purpose of Study

The purpose of this study is to understand the relationship between compassion and employee engagement for nurses involved with addiction and mental illness.

Study Setting and Population

The current study focused on nurses who are members of the International Nurses Society on Addictions (IntNSA). Survey responses were gathered from a worldwide network of nurses working with addiction and mental illness. Nurses represent a variety of settings including inpatient and outpatient addiction treatment facilities at freestanding facilities and hospitals, inpatient psychiatric units, and government facilities.

Definitions

Employee engagement is defined as “a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption,” (Schaufeli & Bakker, 2004, p. 295).

Employee engagement is the level that “employees are fully involved in, and enthusiastic about, his or her work... Engaged employees care about the future of the company and are willing to invest the discretionary effort – exceeding duty’s call – to see that the organization succeeds,” (Seijts & Crim, 2006, p. 1).

Compassion is defined as the awareness to the deep suffering of another and the desire to help relieve that suffering (Chochinov, 2007; Goetz, Keltner, & Simon-Thomas, 2010; Papadopoulos, Shea, Taylor, Pezzella, & Foley, 2016; Schantz, 2007). The Charter for Compassion defines compassion with three elements, 1) a feeling that arises when an individual is aware of the suffering of another, 2) the individual feeling empathy for the person suffering, 3) the individual taking action to lessen that suffering (Kerr, 2015).

It is hypothesized that increased acts of compassion by nurses, towards patients and other nurses, will increase levels of employee engagement. In turn, increased levels of employee engagement will lead to positive outcomes for the medical facility. It is proposed that employee satisfaction and morale will increase as employees find more meaning in their work. An increase in discretionary effort would positively impact patient care outcomes and safety. Acts of compassion, by way of employee engagement, will thus have positive consequences for nurses and the medical facility as a whole.

Summary

Both employee engagement and compassion are integral pieces to medicine and have the power to positively impact patients, healthcare providers, and medical facilities. Due to its positive impacts on employee retention rates, patient care, and patient safety, employee engagement must be a focus for medical facilities that want to achieve better results. The potential link between employee engagement and compassion should be explored to determine if a relationship exists that has the potential to benefit the medical field.

Chapter 2: Literature Review

The current study addresses the following question: What is the relationship between acts of compassion and employee engagement for nurses involved with addiction and mental illness? This chapter delves into previous research conducted for both compassion and work engagement. Examining the antecedents and implications that compassion and engagement have on organizations, specifically healthcare settings, provides context for looking at the relationship between these factors.

Compassion Defined

Compassion has been defined as the awareness to the deep suffering of another and the desire to help relieve that suffering (Chochinov, 2007; Goetz et al., 2010; Papadopoulos et al., 2016; Schantz, 2007). Papadopoulos et al. (2016) described compassion as also encompassing values including empathy, sympathy, kindness, and respect, yet compassion is differentiated by the motivation to take action when the distress of another is recognized.

When providing compassion, it is imperative to understand the context of such actions. Taking into account the cultural background of the receiver is a sign of culturally competent compassion, wherein a compassionate gesture is sensitive to the needs of the receiver (Papadopoulos & Pezzella, 2015). Culturally competent compassion recognizes the receiver's culture, ethnic traditions, and religion when deciding how to provide assistance.

Kanov et al. (2004) presented three elements of compassion: 1) attention to another's suffering, 2) concern for their suffering, 3) taking action to help relieve their suffering. The compassionate response in the workplace can be seen in a variety of ways, including acts of emotional support, assisting with material goods such as donating money to help ease a financial burden, and providing work flexibility by covering responsibilities or work shifts (Lilius et al.,

2008). Compassion is not only taking away another person's pain or suffering, but is about empathetically feeling the sorrow in that moment in order to share their burden while enabling them to retain their independence and dignity during the distressing situation (Von Dietze & Orb, 2000). Compassion can be provided either between two individuals or in a collective environment, such as when an individual is suffering and a group of colleagues join to provide financial support (Lilius, Kanov, Dutton, Worline, & Maitlis, 2011a).

In an organizational context, compassion can be enabled in two ways: 1) indirectly, by creating conditions by which employees initiate unstructured, unplanned acts of compassion; and (2) explicit acts of compassion by which the organization leaders create processes to identify and act in a compassionate manner as appropriate (Lilius et al., 2011a). Factors contributing to an organization with unstructured compassion between individuals include encouraging relationships between colleagues that lead to high quality connections, open communication channels between employees and management, and creating a culture with organizational norms that encourage caring and compassion. Structured compassion includes resources such as employee assistance programs and designated individuals who carry the responsibility of responding to suffering, such as patient care advocates in hospitals (Lilius et al., 2011a).

An example of routinized compassion was discussed by Grant, Dutton, and Rosso (2008) in the context of a retail company that developed an internal support program for employees in need, funded equally by employees and the company. This support program provided an outlet for employees to financially support one another through difficult times. As a result of this shift in company values and the opportunity to contribute financial resources to colleagues in need, employees were able to create positive self-identities related to their generous giving and thus became more committed to the company, thankful that the company gave them that opportunity.

Compassion in Organizations

A culture of compassion has the power to create lasting positive impacts on organizations. Research indicates that compassion can increase employee's commitment to the organization and help employees recover from challenging personal situations, which carries a correlation with reduced employee absences due to distress and increased employee productivity (Lilius, Worline, Dutton, Kanov, & Maitlis, 2011b). It has also been established that positive social interactions between colleagues in organizations have positive effects on the physical health of employees (Heaphy & Dutton, 2008). These benefits demonstrate that a culture of compassion has the power to significantly impact the financials of a company contributing to fewer absences and greater employee productivity.

Lilius and colleagues (2011b) described two conditions that have been recognized as enabling a culture of compassion. One factor is the presence of high quality connections leading to strong interpersonal connections that allow employees to be in tune with each other's needs. The second factor that allows for compassion in the workplace is creating a workspace where employees can share details about their personal lives. When these conditions are present, employees feel they can be open and honest about their personal lives and their challenges, with the understanding that colleagues will empathize and react with care.

Additionally, there are a number of environmental factors in a healthcare setting that encourage compassionate patient care. These factors include personal and professional values, positive role models in leadership, positive relationships between colleagues, and feeling valued and well supported (Christiansen, O'Brien, Kirton, Zubairu, & Bray, 2015).

Impacts of Compassion

Benefits of compassion have been identified for those receiving, witnessing, and participating in the delivery of compassion (Lilius et al., 2011a). Compassion elicits positive emotions among group members. It not only affects the individuals directly involved in the interaction, but also leads to positive reactions among those who witness or are aware of compassionate exchanges. Compassion stimulates feelings of high quality connections among a group as well as feelings of trust that other group members will be supportive in difficult times (Dutton, Lilius, & Kanov, 2007).

In a healthcare setting, it is speculated that patients who receive compassionate care from healthcare providers may recover more quickly from illnesses and better manage long-term health issues (Shea & Lionis, 2010). Compassionate healthcare providers build relationships and trust with patients and families, leading to less patient anxiety. A patient who views his or her physician as compassionate will feel more involved in decision making and trust that the physician has the patient's best interests in mind (Fogarty, Curbow, Wingard, McDonnell, & Somerfield, 1999).

Bramley and Matiti (2014) noted that patients understand their nurses are busy and do not always have the time to develop relationships and are thus appreciative of small gestures of compassion including brief interactions. A reassuring word and compassionate touch can be enough to build trust and decrease anxiety.

Compassion Satisfaction & Compassion Fatigue

Healthcare providers who act compassionately may receive the feeling of compassion satisfaction, which is defined as the positive feelings gained from helping others relieve their suffering (Sacco, Ciurzynski, Harvey, & Ingersoll, 2015). Certain organizational elements are

known to increase the level of compassion satisfaction. These elements include effective communication, multidisciplinary teamwork, collaboration, and trust among team members (Sacco et al., 2015).

Though there are many benefits to creating a culture of compassion, there is also a cost. Healthcare professionals are vulnerable to compassion fatigue, which is the outcome of bearing the extreme suffering of others. Compassion fatigue, one form of burnout (Raab, 2014), significantly inhibits a healthcare provider's capacity or interest in continuing to provide compassionate care (Figley, 2002). If not addressed quickly, compassion fatigue may have permanent implications on a healthcare provider and his or her capacity to provide compassionate care in the future (Coetzee & Kloppe, 2010). The ability to recognize suffering in others, while necessary to provide compassionate care, is ironically also the characteristic that leads to compassion fatigue (Raab, 2014). Age and experience are shown to have a negative correlation with compassion fatigue, with older and more experienced nurses experiencing a lower risk for compassion fatigue (Sacco et al., 2015). Recognizing the causes and presence of compassion fatigue is necessary for healthcare providers, as it can lead to physical and emotional distress.

Due to the emotional and physical energy required to demonstrate compassion towards others, it is imperative for healthcare providers to also be the recipients of compassion from both colleagues and towards themselves. Experiencing compassion and self-care, such as adequate rest and sleep patterns (Smart et al., 2013), provides the necessary support to then provide compassionate care with patients (Shea & Lionis, 2010). Understanding compassion, including the challenges associated, enables healthcare providers to recognize compassion fatigue before it is too late and burnout ensues.

Challenges of Compassion in Healthcare

Two noted challenges faced by healthcare providers in regard to compassion are: 1) a learned detachment and 2) fear of lawsuits. For many healthcare providers who are drawn to healthcare to help others, one lesson they are quickly taught is how to distance themselves emotionally from patients. Care providers are taught to provide a patient or family with bad news in an empathetic but detached manner, understanding and acknowledging but without a genuine connection. However, care providers who numb down emotions in the moment when they are most appropriate are not showing authenticity, leading to a loss of trust (van Pelt, 2008). The fear of lawsuits from patients that originally led to the emotional detachment and the ensuing loss of trust ironically lead to further lawsuits and negative patient interactions. The cycle of emotional detachment and a lack of compassionate patient care then continues.

Organizational and environmental factors such as time constraints, staff shortages, and heavy workloads have also been identified as barriers to compassionate care in healthcare. Additionally, patients or patient's family members acting aggressively or excessively demanding impede a healthcare provider's ability to respond in a compassionate way (Christiansen et al., 2015).

Engagement Defined

Schaufeli and Bakker (2004) defined engagement as “a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption,” (p. 295). Engaged employees are enthusiastic about their organizations and responsibilities and willing to devote discretionary effort in completing their work (Seijts & Crim, 2006). Engaged employees become immersed in their work and connect with their work physically, cognitively, and emotionally (Kahn, 1990). Work engagement differs from job satisfaction, as job satisfaction is a measure of

happiness while engagement is a measure of dedication and absorption in one's work (Bakker, 2011).

Antecedents of Engagement

Multiple authors have commented on factors that affect an employee's level of employee engagement (Bargagliotti, 2012; Wong & Laschinger, 2013; Setti & Argentero, 2011; Leiter & Maslach, 2004; Ram & Prabhakar, 2011). According to Bargagliotti (2012), autonomy and trust emerge as the two antecedents to the work engagement of professional nurses. Trust of the organization, management, and colleagues contributes to levels of engagement as trust enables a caregiver's energy to be directed towards work, rather than concern for the effects of poor decisions by others. Authentic leadership has been shown as another factor with a positive relationship to work engagement (Wong & Laschinger, 2013). Setti and Argentero (2011) similarly identified the factors of autonomy to do one's job, as well as a focus on workload and social support from colleagues and leaders.

Leiter and Maslach (2004) put forth five factors: 1) workload, 2) reward and recognition, 3) sense of community at work through social interaction and support, 4) sense of fairness, and 5) alignment of employee and organizational values. Ram and Prabhakar (2011) identified five factors: 1) job characteristics, 2) intrinsic and extrinsic rewards, 3) perceived organizational support, 4) perceived supervisor support, and 5) procedural and distributive justice. Interestingly, these two authors only agree on one factor, recognition and rewards.

While not using identical language, some of the previous factors are parallel. The need for recognition and rewards is a clear commonality. Additionally, a commonality exists between Leiter and Maslach's (2004) factor of community at work, Ram and Prabhakar's (2011) perceived organizational and supervisor support, and Setti and Argentero's (2011) social support

from colleagues and leaders. Perceived organizational support is the notion that an employer cares about an employee's best interests, while perceived supervisor support is meaningful as the supervisor is seen as a reflection of the organization (Ram & Prabhakar, 2011). These elements allow for social support and a feeling of community among employees. Their impact on employee engagement demonstrates the importance of a nurturing, team-oriented environment. With these factors in mind, a leader has a significant opportunity to make an impact on his or her team's level of engagement (Macauley, 2015).

Research pertaining to healthcare has found a correlation between nursing leadership behaviors and the ensuing work engagement of nurses. Wong and Cummings (2009) suggested that greater work engagement of nurses was demonstrated when leaders were authentic and open in sharing information, contributing to better decision-making that influenced the safety and quality of patient care. In this way, leaders who create an open and authentic environment are making small changes that can have a significant impact.

Kahn (1990) found the presence of three psychological factors that influenced individuals to engage with their work. The first factor, psychological meaningfulness, indicates that the individual feels worthwhile and valued as a result of their contributions. The second factor, psychological safety, indicates a sense of trust, security, and predictability in the situation. The third factor, psychological availability, indicates the individual is physically and emotionally capable of carrying out the work.

Similar to Kahn's (1990) factor of psychological meaningfulness, both Pink (2011) and Kanter (2013) call out the importance of a sense of purpose to stimulate motivation and engagement in employees. Those who find meaning and purpose in their work are motivated to

use their discretionary effort in overcoming challenges if they are personally invested in the outcome (Choi, 2014; Kanter, 2013).

A research report by Penna (2007) found that organizations that dedicate resources to increasing meaning at work could anticipate increased motivation, productivity, and organizational loyalty. The study also referred to a Hierarchy of Engagement with pay and benefits at the base of the hierarchy and meaningful work at the top. The hierarchy indicates that organizations providing a sense of purpose will have a greater level of employee engagement (Penna, 2007).

Engagement's Effects on Employees

There are significant benefits experienced by employees in regard to employee engagement. According to Bakker and Demerouti (2008), engaged employees are happier, healthier, contribute to their own resources, and support an environment where engagement is contagious. To expound upon these items, engaged employees who contribute to their own resources feel higher levels of optimism, self-confidence, and support from colleagues. Engaged employees also receive increased opportunities for job autonomy and task variety (Schaufeli & Salanova, 2007). These positive elements then create conditions for high engagement, yielding a positive cycle. Additionally, engagement becomes contagious among teams as members use their positive energy leading to a motivated, team-oriented work environment where members feed off each other's positive energy and dedication to the work. Engaged employees are found to have better relationships with their employers, thus creating enhanced attitudes, intentions, and behaviors in the workplace (Saks, 2006).

Engagement's Impact on Organizations

Employee engagement is shown to have a positive relationship with organizational performance (Markos & Sridevi, 2010). Engagement has a positive impact on customer loyalty, productivity, and employee turnover (Berry & Morris, 2008; De Lange, De Witte, & Notelaers, 2008). Studies indicate that disengaged employees report a higher likelihood of actively looking for another job, while few highly engaged employees report an intent to leave their current job (Berry & Morris, 2008).

Engagement also impacts workplace safety culture, with engaged employees less likely to have a safety incident. Additionally, employee burnout has a negative relationship to working in a safe manner (Nahrgang, Morgeson, & Hofmann, 2011). Safety incidents for engaged employees are shown to have a lower average cost than disengaged employees with a safety incident (Lockwood, 2007).

Engaged employees are more productive than disengaged employees, with engaged employees more likely to feel that their physical and psychological well-being are positively impacted by their work (Lockwood, 2007). The implication is that engaged employees are more likely to feel their workplace is a healthy environment and are more likely to show support for the organization (Lockwood, 2007).

Employee engagement is also found to have implications for positive levels of customer service (Salanova, Agut, & Peiró, 2005). Employees with necessary organizational resources, such as appropriate training or technology, indicate higher levels of employee engagement, which then relates to a better environment for customer service. Employee engagement is shown to be the mediating factor between organizational resources and a positive service culture (Salanova, Agut, & Peiró, 2005).

Implications of Engagement in Healthcare

In a healthcare setting, the impacts of work engagement are significant. Correlations exist between engaged employees and organizational goals. High levels of engagement lead to employee retention (Berry & Morris, 2008; Collini, Guidroz, & Perez, 2015; Harter, Schmidt, Agrawal, & Plowman, 2013; Lowe, 2012; Simpson, 2009; Tullar et al., 2015). High levels of employee engagement also have a positive relationship with quality of patient care, patient safety culture, and patient-centered care (Harter et al., 2013; Lowe, 2012). Bargagliotti (2012) found that high levels of work engagement in nurses led to higher levels of personal initiative. Positivity then spreads within a workplace, creating a positive environment. This personal and team initiative results in decreased hospital mortality rates. The positive impacts of employee engagement are significant and thus lead to greater financial profitability of organizations due to the positive changes being made.

Also notable is the correlation between job engagement and a healthcare provider's ability to cope with adversity (Vinje & Mittelmark, 2007). Additional findings indicated that deep reflection about the significance of one's work leads to increased levels of job engagement. It can be noted that discovery and reflection of one's passion gives meaning to work and life, allowing for a deeper level of engagement with work and ability to cope with workplace adversity (Vinje & Mittelmark, 2008).

Studies in Canada have shown that high levels of work engagement positively affect healthcare facilities and patient outcomes (Studer et al., 2014). An increase in employee engagement and subsequent decrease in turnover rates led to reduced patient fall rates, increased hand-hygiene compliance, and reduced readmission rates for chronic obstructive pulmonary disease. Another Canadian hospital's increase in employee engagement led to a significant cost

savings in two ways. From a human capital perspective, reduction in lost time injuries, overtime, and sick time saved one hospital \$11.4 million. From a patient care perspective, hospital-acquired infection rates were decreased by nearly half, contributing to a cost avoidance of \$5.7 million.

Despite its many benefits, high levels of work engagement can also have a cost. Job engagement has also been found to stimulate negative factors that put nurses at risk for near-burnout (Vinje & Mittelmark, 2007). For example, nurses who dedicate too much of themselves to the job become more inclined to experience burnout. It is imperative that healthcare providers with high levels of engagement also take time to focus on self-care and self-compassion (Vinje & Mittelmark, 2006).

Compassion & Engagement

Both compassion in the workplace and high levels of employee engagement can have significant impacts on organizations (Markos & Sridevi, 2010; Lilius et al., 2011b; Heaphy & Dutton, 2008). Compassionate interactions affect the giver, receiver, and any witness of the interaction. These benefits, as well as the benefits of having an engaged workforce, can be seen in all aspects of organizational life. Examples include employee satisfaction, retention, and financial outcomes. Benefits have also been recognized when compassion and engagement intersect.

Individual employees who experience joy, interest, and love at work have a higher level of engagement. This is due to the positive interpersonal and social connections developed with colleagues and leadership. Compassion and the ensuing increased level of engagement then relates to improved business outcomes as a result of individuals feeling a deeper connection to other employees, their work, and the company (Harter et al., 2003).

Experiencing compassion in the workplace leads to positive emotions and higher levels of emotional attachment to the organization (Lilius et al., 2008). This positive relationship establishes that experiencing compassion is not just a momentary event, but has lasting implications on employees. The research of Grant et al. (2008) also demonstrated this point, as employees who were able to provide compassion towards colleagues subsequently felt more connected to the organization and a greater level of engagement.

Compassion & Engagement in Healthcare

Healthcare settings are ripe for compassionate interactions between healthcare providers as colleagues and towards patients and families. Opportunities to provide compassion are constant and creating a culture of compassion that encourages shared compassion between colleagues and towards patients can have lasting implications on healthcare providers (van Lieshout, 2015).

The absence of compassion also has an effect on employees. Incivility between nurses has resulted in job dissatisfaction and reduced organizational commitment (Laschinger, Leiter, Day, & Gilin, 2009). Laschinger and colleagues (2009) found that compassion between nurses in a healthcare setting would create more civil interactions and thus create a more positive workplace with increased levels of job satisfaction and engagement.

Lastly, Mason et al. (2014) examined the relationship between compassion satisfaction and work engagement in nurses, finding a positive relationship between these factors. This conclusion revealed that as work engagement increases, compassion satisfaction also increases. It is this correlation that can be explored further to understand the effect of compassion on the levels of work engagement in nurses.

Summary

To summarize, there are significant benefits of both compassion in the workplace and high levels of employee engagement. These benefits are magnified in a healthcare setting, as there are lasting positive implications for healthcare providers and patients. Despite previous research, the impact that acts of compassion have on levels of employee engagement in a healthcare setting remains unknown.

Chapter 3: Research Methodology

The purpose of the current study is to understand the relationship between compassion and employee engagement for nurses involved with addiction and mental illness. The current study will examine the relationship between self-reported acts of compassion of nurses associated with the International Nurses Society on Addictions and their level of employee engagement. It is hypothesized that increased self-report of compassionate acts will have a positive relationship with higher levels of employee engagement.

This chapter presents the research design, data sample and collection procedures, and data analysis procedures.

Research Design

The current study is a two-part mixed methods design. The research design included a quantitative engagement survey, the validated 9-item Utrecht Work Engagement Scale (UWES-9), and a qualitative semi-structured interview of self-reported compassion.

Data Sample and Collection

Data was collected using an online survey questionnaire (Part 1) followed by semi-structured interviews (Part 2).

Part 1: Sample A.

A sample of convenience was obtained from a population of nurses who are members of the International Nurses Society on Addictions (IntNSA). According to its website:

“The International Nurses Society on Addictions (IntNSA) is a professional specialty organization for nurses committed to the prevention, intervention, treatment, and management of addictive disorders including alcohol and other drug dependencies, nicotine dependencies, eating disorders, dual and multiple diagnosis, and process addictions such as gambling.”

Part 1 of the study was the engagement survey. The engagement questionnaire was e-mailed by the IntNSA executive director to group members with an invitation to voluntarily complete the engagement survey. The questionnaire included the informed consent, confirmation that the participant had direct patient contact, demographic information (Appendix A), and the nine-item engagement survey (Appendix B). The final question on the survey invited participants willing to do a follow up interview with the researcher to include their contact information. Sample A consisted of 119 responses received from the engagement questionnaire. One questionnaire was disqualified due to the participant not having direct patient contact. Using UWES-9 scores, the survey results were then categorized into 1) very low, 2) low, 3) average, 4) high, and 5) very high engagement. These categories were established by Schaufeli & Bakker (2003), as determined by the distribution of the norm scores and the standard measurement error. Table 1 depicts the UWES norm scores. Survey results for Sample A were distributed among engagement levels as represented in Table 2.

Table 1

Utrecht Work Engagement Scale Norm Scores

Engagement Level	Norm Scores
Very Low	≤ 1.77
Low	1.78-2.88
Average	2.89-4.66
High	4.67-5.50
Very High	≥ 5.51

Table 2***Sample A Engagement Level Frequency***

Engagement Level	Frequency
Very Low	0
Low	4
Average	48
High	56
Very High	10

Part 2: Sample B.

From 118 responses, 48 participants voluntarily provided contact information to be selected for the second phase of the study. Engagement scores were then determined for these 48 participants using their UWES-9 survey results and grouped by engagement score, as represented in Table 3.

Table 3***Sample B Engagement Level Frequency***

Engagement Level	Frequency of Participants Volunteering for Part 2
Very Low	0
Low	1
Average	23
High	19
Very High	5

Due the low responses in the low and very high categories, these participants were selected for Sample B. A random sample of five participants was selected for participants in the average category with every fifth name chosen for the sample. A random sample was selected separately for participants in the high category with every fourth name chosen for the sample. As

no participants in the very low engagement category volunteered for Sample B, no participants were selected. A total of 16 participants were selected for Sample B.

The 16 participants selected for Sample B were e-mailed by the researcher with an invitation to participate in an interview with the researcher (Appendix C). From these participants, there was no response from the participant with low engagement and therefore this category was not represented. Three participants each from average, high, and very high categories (nine total) responded and were interviewed. Two additional participants from average and high categories were selected via random sample in an attempt to achieve a sampling of five participants in each of these categories. However, no response was received and the study was completed with a sampling of three average, three high, and three very high engagement participants.

The e-mail invitation included informed consent with information about the research topic, risks, and benefits associated with their participation. Additionally, consent requested that the interviews be audio-recorded for data collection. Consent was implied with the participants responding to the e-mail with their confirmed interest in participating.

An interview time was scheduled with each participant who responded back to the researcher. Interviews were conducted by phone and the participants were asked permission to begin audio recording. Interviews were only recorded after verbal consent from the participant.

Participants were interviewed in a semi-structured interview format (Appendix D). The interview gathered data regarding participant's self-reported compassion as experienced in their workplace. The interview began by defining compassion. The researcher's views were not shared with the participants.

Protection of Human Subjects

Institutional approval to conduct this study was received by the Institutional Review Board at Pepperdine University on September 6, 2016 (Appendix E). The researcher completed human subjects training through Collaborative Institutional Training Initiative on September 13th, 2015 (Appendix F).

Part 1: Sample A.

In Part 1 of the study, a link to the survey was sent by e-mail. The Survey Information/Facts Sheet was the first page of the survey, explaining the research study and voluntary nature of participation. Clicking “I agree to participate” and beginning the survey implied participant consent. Participants were invited to close out of the survey and not respond to the questions if they did not want to participate. There were no apparent risks to participate in this survey.

All survey responses were kept confidential. Confidentiality of data was protected, as participants did not have to self-identify to complete the study. Volunteers were solicited to participate in Part 2 of the study and to volunteer, participants were asked to self-identify and provide contact information. The data will be stored on the researcher’s password protected computer and retained for three years following the study. Only aggregate data was reported in the research.

Part 2: Sample B.

In Part 2 of this study, a random sampling of participants from Part 1 were contacted by e-mail to voluntarily participate in Part 2. The e-mail included the informed consent with information about the research study and any benefits and risks associated with their participation. Foreseeable risks of participation included minor discomfort during the interview

as the participant recalled experiences from the workplace. Participant consent was implied by the participant's response to the invitation e-mail with their interest in participating.

All participant responses were assigned a pseudonym to protect participant identity, with the pseudonym linked to both the UWES-9 and responses to the interview questions regarding self-reported compassion. Individual participant responses were kept confidential. Data was reported in the aggregate and any quotes from the interview were reported with a pseudonym.

Interview responses will be retained on the researcher's password-protected computer for three years, at which point they will be destroyed. Interview audio-recordings do not have any identifying information. Audio-recordings and transcripts from audio-recordings will be retained for three years on the researcher's password-protected computer, at which point they will be destroyed.

Instrumentation

Two instruments will be used to collect data for this study: the nine-item Utrecht Work Engagement Scale (UWES-9) and a semi-structured interview to gather data on participants' self-reported compassion.

Utrecht Work Engagement Scale.

The instructions for the UWES-9 asked participants to read each statement and decide if they ever felt a specific way about their job. A rating scale indicated that if the participant never experienced the feeling, select a rating of "0" (zero). If the participant has had the feeling, they were to indicate how often selecting a number (from 1 to 6) that best described the frequency of the feeling, with 6 being the highest. The UWES-9 survey questions were as follows:

1. At my work, I feel bursting with energy.
2. At my job, I feel strong and vigorous.
3. I am enthusiastic about my job.
4. My job inspires me.

5. When I get up in the morning, I feel like going to work.
6. I feel happy when I am working intensely.
7. I am proud of the work that I do.
8. I am immersed in my work.
9. I get carried away when I am working.

Work engagement has been defined with three dimensions: vigor, dedication, and absorption (Schaufeli et al., 2006). The nine-item survey has three scales within to measure each dimension: 1) vigor scale, 2) dedication scale, and 3) absorption scale. Only the total engagement scores were evaluated in this study and engagement scores were not analyzed by dimension.

The UWES-9 has been validated: “Factorial validity was confirmed using confirmatory factor analyses, and the three scale scores have strong internal consistency and test-retest reliability,” (Schaufeli et al., 2006, p. 701).

Self-Reported Compassion Interview.

The interview began with the definition of compassion and three examples of acts of compassion. A semi-structured interview was conducted using the following questions:

1. Tell me about a time when you acted compassionately towards patients, families, or coworkers.
2. How many times per day would you estimate you act compassionately towards patients or coworkers?
3. What factors enable you to act compassionately?
4. What are barriers that prevent you from acting compassionately?
5. Do you witness your fellow nurses acting compassionately? How many times per day/week?
6. What energizes you at work?
7. What depletes you at work?
8. Can you tell me about a time when you felt especially appreciated by a patient or coworker?
9. Can you tell a story about a particular incident or patient that stands out in your mind as a time when you acted compassionately? After that incident, how did you feel about your job?

Data Analysis

Descriptive statistics were used to analyze data from Sample A. Responses from Sample B were transcribed verbatim and the qualitative data was analyzed. Key themes were analyzed for each interview question. Subsequently, interviewees were paired with their engagement score (average, high, and very high) and compassion findings were analyzed in relation to interviewee engagement scores.

Summary

In summary, this chapter described the research methods and procedures used to examine the relationship between engagement and compassion for nurses working with addiction and mental illness. This chapter presented the study design, data sample and collection, protection of human subjects, instrumentation, and data analysis. The results of this study will be presented in Chapter 4.

Chapter 4: Results

The purpose of the current study was to understand the relationship between compassion and employee engagement for nurses involved with addiction and mental illness. The sampling methodology and results of the current study are presented in this chapter.

Sampling Methodology

As previously outlined in Chapter 3, Sample A included 118 respondents of a work engagement survey. Survey results for Sample A were distributed among engagement levels, as displayed in Figure 1.

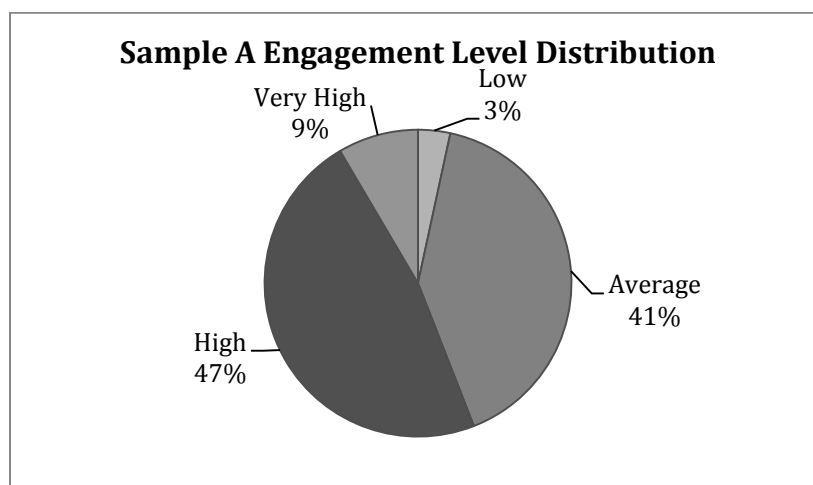


Figure 1

Sample A Engagement Level Distribution

The researcher intended to conduct a total of 30 interviews with equal participants of very low, low, average, high, and very high engagement. Due to no survey results from participants with very low engagement and only one participant with low engagement volunteering for Part 2 of the study, the researcher adjusted to a goal of 16 participant interviews with a breakdown including one low engagement participant and five participants each from average, high, and very high. Participant response included three average, three high, and three

very high engagement participants. The researcher attempted to contact additional participants, including two average and two high engagement participants, but there was no response.

Ultimately, interviews were conducted with 9 participants including: three average engagement, three high engagement, and three very high engagement participants. All participants were asked the same semi-structured interview questions.

Engagement Survey Findings

The findings from the engagement survey are reported in the subsequent sections.

Sample A consisted of 118 nurses with direct patient contact who were members of the International Nurses Society on Addiction.

Respondent engagement.

Total engagement scores ranged from 1.89 to 6.00. The mean engagement score for participants is 4.56. Median and mode engagement scores were both 4.67. Standard deviation was 0.86. The normal distribution curve of engagement scores for Sample A is indicated in Figure 2.

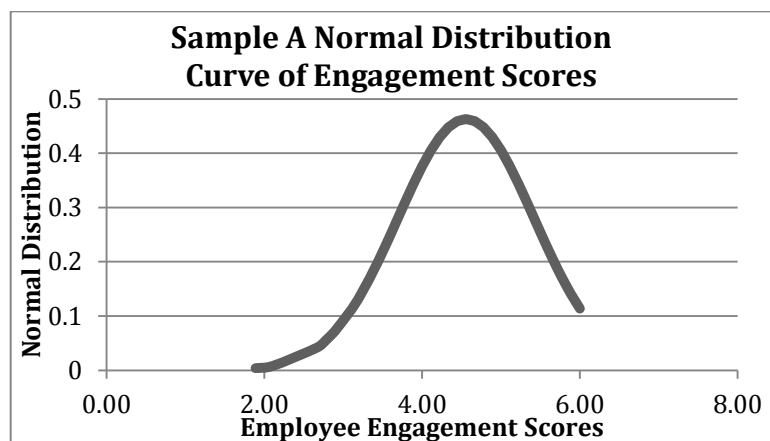


Figure 2

Sample A Normal Distribution Curve of Engagement Scores

Age demographics.

Of the 117 participants who disclosed age, participant age ranged from 22 to 76 years of age, with a mean of 50.60 years of age, median of 54 years of age, and a mode of 62 years of age. A correlation coefficient of 0.06 indicated no correlation between engagement score and age. Figure 3 notes the mean engagement scores for each age represented in the engagement survey.

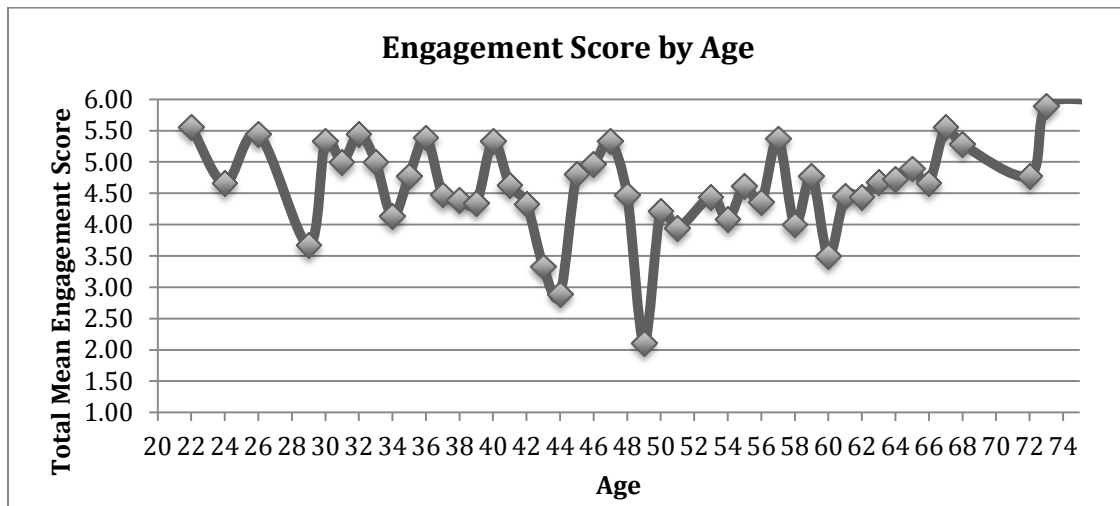


Figure 3

Engagement Score by Age

Experience level.

Survey respondents selected their experience level, indicating one of five options: 1) 0-2 years, 2) 3-5 years, 3) 5-10 years, 4) 10-15 years, 5) 15+ years. Responses were distributed among the 5 experience levels. Figure 4 represents the experience level of the survey respondents.

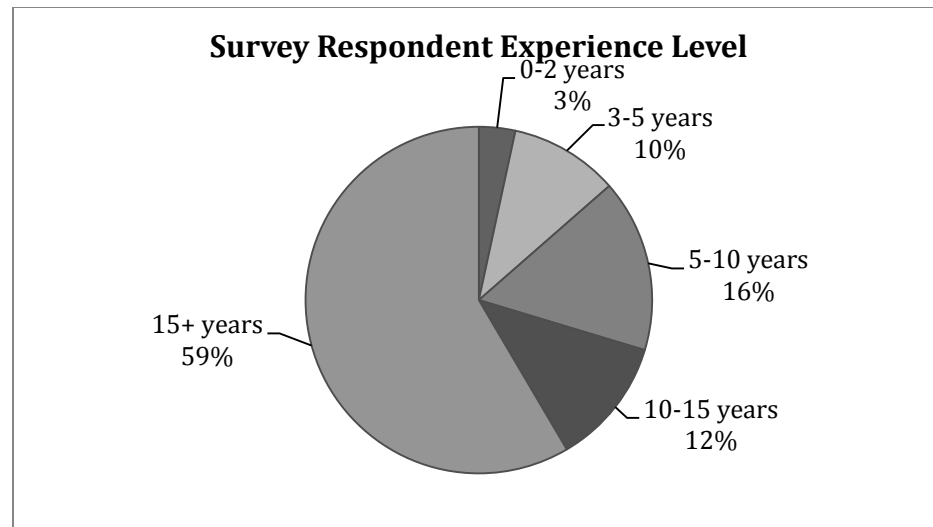


Figure 4

Survey Respondent Experience Level

Compassion Interview Findings

The findings of the semi-structured interview are reported in the subsequent sections. As reported by the interviewees, time and resources are the biggest factor to providing compassion to this specific patient base. As described by the interviewees, the best form of compassion for patients in recovery is spending time with them and listening to them. It's not "going out of your way" for a patient, but using a compassionate approach in doing every day tasks in a non-judgmental way.

Unique brand of compassion.

When describing their compassionate actions in the workplace, all interviewees described an experience when they took the time to listen to a patient or coworker. Providing care to people with addiction and mental illness was described as requiring a "unique brand of compassion" due to the specific patient population. This was described by four of the 9 participants. One participant noted the distinction between the needs of the patients in recovery versus other types of care:

“Down in psychiatry, it's interesting. It's a difficult challenge. They're up and walking around, they don't have big gaping wounds and they're in a great deal of pain and actually it's a bit more challenging at times to use empathy and put yourself in their shoes because you have to try to understand what they're going through in their life, what's causing them to feel badly.”

Additionally, it was noted by two participants that due to a patient's mental and emotional state, the compassion provided by nurses is not always perceived as compassion by the patients. One participant explained, “The thing about addiction is you have to meet them with firm kindness... and it may be seen in our field as being compassionate but sometimes the patient will not see it that way because you're not allowing them to continue their disease.” Another participant echoed this sentiment, “I have to compassionately do a dance where I'm nursing them back to health by making them more independent”.

Emotion.

Three participants were overcome with emotion while on the phone discussing their experience with compassion. One participant became emotional while describing a specific patient who may not recover due to extensive drug use. A second participant became emotional while recalling a story in which she was the patient and did not receive compassionate care, an event that inspired her to go into nursing. A third participant became emotional while describing her impact on the patients and attempting to make a difference in people's lives, then explaining how even if she helps just one patient then she knows she made a difference.

Four participants described a personal experience that drove them into this particular line of nursing, either with their own history with addiction or a family member struggling with addiction or mental illness. These participants described using their personal experiences to help patients through their recovery in a non-judgmental way. One participant explained, “I am a

recovering drug addict and a lot of my compassion comes from where I've been and the realization that there's a lot of good in everyone.”

Self-reported number of daily acts of compassion.

Interviewees were asked to estimate how many times per day they act compassionately. Eight participants indicated that they try to show compassion with every patient during each interaction. Responses ranged from estimating “3-5 times per day” to “5, 6, 7 times per hour”.

Factors that enable and hinder compassion.

Having enough time is a major factor that enables compassion, as mentioned by seven participants. Additionally, interviewees mentioned one benefit of the nature of the treatment process was having a prolonged period of time to get to know the patients. One participant explained, “Most of these patients I have for about a month and so the ease of conversations or building relationships over time is really nice. I didn’t get that opportunity in critical care as much. I have more opportunity to listen to patients.”

Another factor that enables compassion is support and encouragement from the medical facility environment, coworkers, and supervisors as reported by four interviewees. One participant described her work environment as enabling a greater level of compassion towards patients and described the emphasis that the facility places on employee wellbeing and how that also impacts patients:

“We have a big environment, we have the ability to move patients if we need more room or if they need more comfort. They have leather chair recliners, we have coffee available, water available, we do everything we can. I guess I have my resources available and it's important to our employer. The physicians and the owners, they want the employees happy and if the employees are happy that trickles down to treating the patients better.”

Although not specifically indicated as an enabler by interviewees, the nurses’ passion for their jobs came forth as a distinguished enabler of compassion. All interviewees exhibited or

voiced, without prompting by the researcher, their passion or love for their job at some point during their interview in the course of describing their experience with compassion. Passion and love for their job and the patients provided the desire to provide compassionate care, despite barriers with both the environment and the patients.

Interviewees mentioned significant barriers to providing compassion, specifically with the environment and the population of patients. Three interviewees described a lack of time to spend with the patients. One participant explained, “I would say that we try to make time but I don’t feel like it’s 100% done because we don’t get paid for therapy”. Another participant described the need for prioritizing the needs of the patients, “If I’m really pressed I’ve got to prioritize the patients needs quicker and maybe the compassion is a little bit lower than delivering the medication on time”.

The specific needs of patients in recovery for addiction and mental illness was explored by three interviewees. These interviewees described having distinct boundaries with patients, unlike in other areas of nursing. Patients directing verbal abuse and manipulation toward the nurses hindered the nurses’ abilities to provide compassionate care, as the nurses were forced to change their tactics in working with these challenging patients. One participant explained:

“The verbal abuse is the worst. Patients call you names, different things like that, and just difficult behavior. That really is very draining. It’s like being in a fight with someone. No one likes to be in a fight, but especially worse is being a nurse in that situation because you can’t really- and this isn’t the best expression - but you can’t fight back. I mean you can up to a point, you can try to redirect the patient and say look this isn’t appropriate behavior, I’m your nurse please don’t call me that, and things like that. But in the end you can’t force people to not say certain things, so that is extraordinarily draining because you feel very helpless and beaten in those situations because you don’t, there’s nothing you can do to protect yourself in that situation.”

The challenging environment led to nurse burnout and a negative workplace, as described by three interviewees. One participant described their experiences in working with manipulative

patients: “Compassion and burnout really become a toxic problem because instead of actively working to work and treat them, you just get to the point where you don't believe people anymore.”

Four interviewees explained that the physical boundaries with patients in recovery are different from patients in other areas of medicine. Due to their unpredictability, patients in recovery were not to be physically touched (hugs, touching a hand) whereas these actions may have been seen as compassionate gestures for other patients. One participant described, “I don’t physically show compassion with these type patients. You have to have boundaries. I don’t hug these patients, I don’t even shake their hand.”

Working with limited resources and a challenging patient population are barriers to providing compassionate care. Four interviewees explained that these challenging circumstances limit their emotional and physical capabilities in providing compassion. Interviewees described the importance of self-care to combat working with difficult patients and regain their ability to act compassionately. One participant explained:

“That population is extremely challenging. They say the lifespan in this department is typically one to two years and I've been here for four and still love it. I have my days, the last two days have been really rough, but as long as I can get my mental health days back and take some down time to regroup I'm ready to start back in again.”

Witnessing compassion.

All interviewees discussed witnessing compassion in their workplace, either amongst nurses or witnessing nurses treating patients with compassion. All interviewees described witnessing coworkers acting compassionately consistently throughout the day. The examples of witnessing compassion mostly involved nurses spending the time to talk with patients who were having a difficult time, as mentioned by seven interviewees.

Three interviewees also described witnessing their colleagues providing resources to patients, both in the facility and as the patients were preparing to leave. One participant explained one such incident, “It's not in our job to do case management like finding people housing or giving them numbers for different things but last week I saw someone compassionately finding a bus route for someone.” Another participant described a similar experience with witnessing compassion, “So I think it's all of us all day long. Kind of advocating for the patient, maybe ... we'll call the probation officer, make calls, write letters, that kind of thing to keep them in treatment. Assist them with food stamps. We do a lot of that kind of stuff.”

Energizing and depleting forces.

All interviewees described being energized by helping people and making a difference for their patients. One participant explained, “When you truly see someone dedicated to getting their life together and getting sober, and you see them actively involved and growing. That is such an inspiration to tell you I'm in the right place. I'm helping someone. I love my job. I love my profession.”

Seeing patients recover was another energizing force for six interviewees. One participant shared his experience, “It energizes me to see someone grow both physically and mentally over a two-week period. I get to come to work every day and see those changes”. Another participant agreed, “It's a rewarding system when people are motivated to get better.”

When asked about energizing forces in their workplace, three interviewees spoke of the positive energy that comes from supportive colleagues. One participant clarified, “Being around other coworkers that want to be there. That really, really want to work there because they have a heart for this”. Another participant described the energizing support she received from the facility physician’s expression of gratitude, “Every night he walks in and says good night and

he's leaving and 'thanks a lot guys'. So you want to do good for him. So that kind of gives you energy, someone saying 'thank you' and 'you're doing a good job'".

On the opposite side of the spectrum, two interviewees described the negativity experienced with unsupportive colleagues who are not working as a team. One participant described a depleting factor as, "Coworkers who don't really want to work or help or work as a team". Another participant echoed this sentiment, "Negativity from a coworker zaps energy, either towards their job or the company I work for."

Unsupportive management was also described as a depleting factor, with three interviewees describing the challenges with managerial involvement. One participant provided an example of the staff attempting to discharge aggressive, verbally abusive patients:

"We put limits on their behavior and then they [management] comes behind us and says 'no we don't want to discharge them' even though they're being verbally abusive or bullying other patients or staff and being totally inappropriate, that bothers me more than anything. When management isn't supportive."

Three interviewees described the effects of being short-staffed, impacting their ability to help the patients and provide compassionate care. One participant described this factor, "I'd have to say staffing is a major issue in that there are so many people you have to work with and help and you don't have the time and energy to get everything that you wished or hoped you could have done."

Fighting for resources came forth as a depleting factor, with three interviewees explaining this. The interviewees described fighting with insurance companies on behalf of the patients to get pre-authorizations and medications. One participant elaborated, "Not having resources, like with the insurance company. Jumping through hoops, sitting on the phone... We

have pharmacy issues... maybe the pharmacy loses the script and I have to make 15 phone calls to get that situated... When things are difficult for the patients.”

Experiencing appreciation.

All interviewees described being appreciated, whether by a patient, supervisor, or colleague. Seven interviewees described receiving appreciation from patients who thanked them for their help. One participant explained, “Once in a while a patient says ‘thank you, I appreciate what you did, I appreciate you talking to me’. And it doesn't happen all the time but once in a while it does.” Another participant noted the difference in appreciation between psychiatric patients and other departments:

“It's a big difference. When I was in med. surg. and ICU CCU, you had patients the families would send food to the staff, you know, fruit baskets, cookie trays, all that kind of stuff. You don't get that as much in psychiatry. A lot of these don't have insurance, they're not employed, they're not working. They don't have the funds to show appreciation that way. So it's a little different, you know? It's more by mouth and by writing letters. I don't get that many. It's a little different the way they show appreciation in psychiatry I've found over the years versus when I worked in ICU CCU. But it's ok.”

One participant described feeling appreciated after a coworker informed her that they had unknowingly saved a patient's life, as he was going to commit suicide the day that the participant called and gave the patient a bed in the treatment facility. This participant emotionally recalled this experience and the impact on her:

“You have no idea how many seeds you plant ... Because even if you say or do something for a patient and you think it's going on deaf ears, and ten years later they come back and say ‘yeah, when you said such and such, that really made a difference and I just want you to know how much that impacted me’. And I feel like we're all that way, we all say things and do things in our life that we feel fall on deaf ears or we feel like we're not making a difference, and we have no idea how much we're benefitting others.”

Three interviewees described being appreciated by their supervisor or management. One participant described the quarterly performance review process, “People go into that with fear ...

but there's a lot of positivity in that. And ... it's not a review with someone in HR that's looking at how many times you were sick, or late, or what you've done wrong lately. It's a real conversation.”

Four interviewees described being appreciated by their colleagues. One participant explained that a feeling of appreciation comes with being valued for her expertise, “I feel really good when they run things by me or want me to explain things. I feel good when they trust me to give them information.” Another participant described a situation in which a coworker was experiencing a medical emergency and she rushed to his aid. In the aftermath, this participant explained, “He and I had known each other by working together but we weren't that close, but that drew a common bond for us and he's been very thankful ever since.”

Expressing compassion.

Interviewees were asked: “Tell a story about a particular incident or patient that stands out in your mind as a time when you acted compassionately. After that incident, how did you feel about your job?” As a result, stories about instances of compassion included interviewees 1) taking action to help a patient, 2) spending time with a patient, or 3) expressed compassion in the way they handled their daily responsibilities.

Three interviewees described taking action outside the scope of their typical responsibilities to relieve a patient’s suffering. One participant described a homeless patient whose winter coat was ripped and she brought in a sewing kit to sew his sleeve. When asked how that incident made them feel about their job, the participant responded, “Made me want to help people a little bit more, be a little bit kinder, gentler. He felt that I cared... I wish we could do that for everyone”.

Five interviewees described acting compassionately by making connections with the patients and giving of their time. One participant described taking the time to explain a recommended therapy to a patient. When asked how this incident made them feel about their job, they replied:

“Oh, a lot better. Because there are times you feel like a robot in the med. room, handing out pills and it really makes you feel ineffective, it really makes you feel helpless, as if you're really not able to do anything to help these people. When you can do things like that, and make connections with people like that, it does make you feel as if well maybe you can achieve something.”

Two interviewees expressed compassion in the way they went about their daily tasks. Both interviewees described situations where they had to help a patient by involuntarily committing them to the psychiatric ward. Both interviewees described how difficult this situation can be and how their compassionate approach makes the experience more positive for the patients. One participant described this situation:

“It's hard to do that [involuntarily commit a patient] and get them to realize you're not punishing them... This patient came back to me and they had been involuntarily committed before and had a traumatic episode in their mind that was and how devastating that was, they felt so denigrated... and being punished because they put them in handcuffs and so forth. But the way I explained it, she didn't feel that way. She didn't feel she was being punished. She told me it shaded how she felt and how she did in the hospital because it didn't start out on such a negative note. Even though she was involuntarily committed she looked at it a different way, with a different perspective because of the way I explained it, what was happening and why it was a benefit, and why it wasn't a negative or punishment or punitive for her. And that really stuck with me. Whenever I have to do that I make sure I explain everything so they don't have that negative connotation.”

When asked how they felt about their job after this incident, the participant responded, “I felt better. It kind of reinforced why I do what I do. I like helping people.” After sharing a similar story, another participant described how they felt about their job, “I've always loved it. I never have any doubt about what I'm doing. I love it. I absolutely love it.”

Engagement Survey and Compassion Interview Findings

The findings for the engagement survey and compassion interviews are reported in the subsequent sections. Nine interviews were conducted: three interviewees with average engagement, three interviewees with high engagement, and three interviewees with very high engagement.

Unique brand of compassion and engagement results.

Four interviewees described their patients as requiring a “unique brand of compassion”. Three interviewees had high engagement and one interviewee had very high engagement.

Emotion and engagement results.

Three interviewees displayed emotion during the interview as they discussed their experiences with compassion. One interviewee had average engagement and two interviewees had very high engagement.

Daily acts of compassion and engagement results.

The number of self-reported daily acts of compassion was examined in relationship to the reported level of engagement. The average frequency of daily acts of compassion was determined by calculating the average frequency for each interviewee then calculating the average frequency per engagement level. Figure 5 represents the average frequency of daily acts of compassion by engagement level.

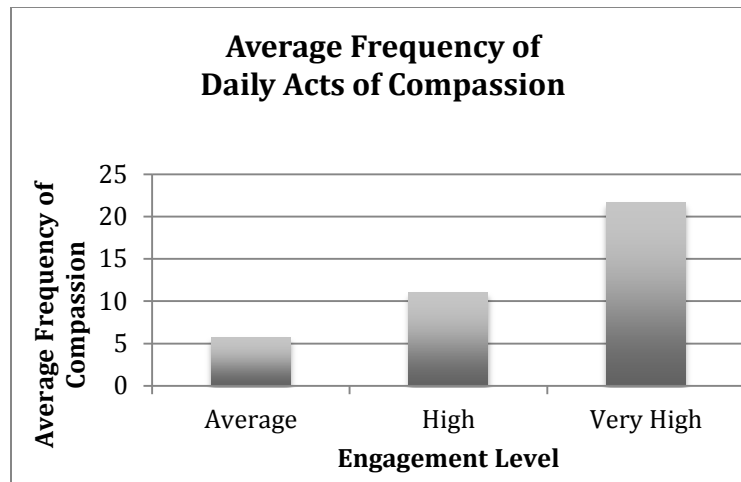


Figure 5

Average Frequency of Daily Acts of Compassion

Factors that enable and hinder compassion and engagement results.

Table 4 summarizes the factors that enable compassion and the frequency of interviewees who indicated that factor from each engagement level.

Table 4

Frequency of Interviewees by Engagement Level Describing Factors that Enable Compassion

Enablers of Compassion	Average Engagement	High Engagement	Very High Engagement	Total
Having enough time	3	1	3	7
Support from colleagues & supervisors	2	1	1	4
Passion for nursing	3	3	3	9

Table 5 summarizes the factors that are barriers to compassion and the frequency of interviewees who indicated that factor from each engagement level.

Table 5

***Frequency of Interviewees by Engagement Level Describing Factors as Barriers to
Compassion***

Barriers to Compassion	Average Engagement	High Engagement	Very High Engagement	Total
Lack of time	1	2	0	3
Challenging patient population	0	1	2	3
Burnout & negativity in workplace	1	2	0	3
Physical boundaries	2	0	2	4
Limited emotional/physical capabilities	1	2	1	4

Witnessing compassion and engagement results.

Table 6 summarizes the interviewee's experience in witnessing acts of compassion and the frequency of interviewees who indicated that experience from each engagement level.

Table 6

Frequency of Interviewees by Engagement Level Witnessing Compassion

Witnessing Compassion	Average Engagement	High Engagement	Very High Engagement	Total
Nurses talking with patients	2	3	2	7
Nurses providing resources to patients	0	1	2	3

Energizing and depleting forces and engagement results.

Table 7 summarizes the energizing forces of compassion and the frequency of interviewees who indicated that factor from each engagement level.

Table 7

***Frequency of Interviewees by Engagement Level Describing Energizing Forces of
Compassion***

Energizing Forces	Average Engagement	High Engagement	Very High Engagement	Total
Helping people	3	3	3	9
Seeing patients recover	2	1	3	6
Supportive colleagues	2	0	1	3

Table 8 summarizes the depleting forces of compassion and the frequency of interviewees who indicated that factor from each engagement level.

Table 8

Frequency of Interviewees by Engagement Level Describing Depleting Forces

Depleting Forces	Average Engagement	High Engagement	Very High Engagement	Total
Unsupportive colleagues	2	0	0	2
Unsupportive management	2	0	1	3
Short-staffed	1	2	0	3
Fighting for patient resources	1	1	1	3

Experiencing appreciation and engagement results.

Table 9 summarizes the interviewees experience with appreciation in the workplace and the frequency of interviewees who indicated that experience from each engagement level.

Table 9

Frequency of Interviewees by Engagement Level Describing Experiencing Appreciation

Experiencing Appreciation	Average Engagement	High Engagement	Very High Engagement	Total
Appreciation from patients	1	3	3	7
Appreciation from supervisors	2	0	1	3
Appreciation from colleagues	2	0	2	4

Expressing compassion and engagement results.

Table 10 summarizes the level of engagement for each interviewee's example of a compassionate interaction in the workplace.

Table 10

Frequency of Interviewees by Engagement Level Describing a Compassionate Interaction

Compassionate Interaction	Average Engagement	High Engagement	Very High Engagement	Total
Specific action	1	1	1	3
Spending time with patients	2	2	0	4
Compassion in daily tasks	0	0	2	2

Summary

This chapter presented the findings of the study. The first section described the results of the engagement survey. The second section described the results of the semi-structured interview with nurses to explore their experiences with compassion in the workplace. The third section presented the findings of the compassion findings in relation to the interviewee's levels of work engagement.

Chapter 5: Research Overview

The purpose of this study is to understand the relationship between compassion and employee engagement for nurses involved with addiction and mental illness. Knowledge of this relationship will enable medical facilities to better understand the impact that compassion and employee engagement have on each other and take action. Review of the available literature indicates that independently, employee engagement and compassion both have significant positive impacts on a medical facility through positive effects for both patients and healthcare providers. Therefore, leveraging a relationship between compassion and employee engagement can multiply those positive impacts. This chapter concludes the research study by discussing and interpreting research findings, as well as study limitations and recommendations for future study.

Conclusions

A review of the data findings indicates two conclusions.

Finding 1: Data Confirms Previous Research Findings.

The compassion research data confirmed previous research on the topic in four ways. First, previous research indicated the need for nurses to receive self-compassion and self-care to then provide compassionate care to others (Shea & Lionis, 2010; Smart et al., 2013). This was confirmed by the research data as interviewees described the importance of self-care to combat working with difficult patients and regain their ability to act compassionately.

Second, previous research indicated that the structure of an organization impacts compassion. Lilius et al. (2011a) described compassion as being enabled by an organizational structure in two ways: 1) indirectly, by creating conditions for unstructured acts of compassion or 2) directly, by creating processes to identify and act compassionately. The research findings confirm the presence of an organization enabling compassion indirectly, as interviewees

described a workplace that enabled them to act compassionately due to the organizational structure providing both time and supervisor or coworker support.

Third, the need for positive interpersonal connections with coworkers was confirmed by this research. Lilius et al. (2011b) described the importance of high quality connections that enable a culture of compassion. The research data confirms this as interviewees described coworker support as both an enabler of compassion and an energizing force of compassion. Interviewees also described unsupportive coworkers as a depleting force of compassion.

Fourth, organizational and environmental factors such as time constraints and staff shortages were identified as barriers to compassionate care (Christiansen et al., 2015). This was confirmed by the research data as lack of time, staff shortages, fighting for patient resources, and unsupportive management were all described as barriers to compassion or depleting forces in the workplace. This confirms previous research as organizational and environmental factors were presented as challenges in providing compassionate care.

Finding 2: Participant View of Topic.

The second conclusion from the data is the importance of this topic from the viewpoint of the nurses who participated in the study. This can be a bias in the way that the participants who volunteered did so because of their connection to the topic. However, all of the interviewees voiced to the researcher the importance of compassion in their work. Seven interviewees shared that they were happy to be involved in the study and personally felt a relationship between compassion and engagement in their work. Four interviewees openly displayed emotion during their interviews while describing their experiences with compassion. After the researcher described the research topic to one participant, she responded:

“I absolutely think there’s a relationship, the trouble is how do you describe it? I struggled for years with how do you give a patient hope? Where does it come from, what does it look like? And that’s sort of what you’ve got with compassion. How do you measure it? How do you find it? What’s it going to look like?”

With this reply, this participant described a limitation of the study, a challenging topic to explore as compassion is exhibited differently in every person and every situation.

Findings Applied to the Research Question

A review of the research findings includes two conclusions.

Research Finding 1: A Trend in Average Frequency of Daily Acts of Compassion per Engagement Level.

First, one trend that was present in the data was an association of the average frequency of daily acts of compassion per engagement level. As engagement level increased, acts of compassion also increased. This trend is in line with previous research, as high levels of employee engagement were found to have a positive relationship with patient-centered care (Harter et al., 2012; Lowe, 2012) and engaged employees were found to have better relationships with their employers, creating enhanced attitudes and behaviors in the workplace (Saks, 2006). Despite this apparent association, it is possible that engagement level and frequency of daily acts of compassion are impacted by a confounding variable, a topic to be explored in further research.

Research Finding 2: Inconclusive Relationship between Compassion and Employee Engagement.

The second conclusion indicates an inconclusive relationship between employee engagement and compassion for the sample population of nurses from the International Nurses Society on Addictions. Without participation from nurses with low engagement and very low

engagement, it is impossible to determine a clear trend between engagement levels and compassion.

Study Limitations

Limitations exist because of the narrow scope of this study. Engagement survey and interview data are restricted due to lack of participation by nurses with low engagement and very low engagement. This can be attributed to nurses with low and very low engagement choosing to not participate in a research study about engagement. Additionally, the small group of participants in this study may not represent the greater population of nurses who work with addiction and mental illness, or the greater population of nurses in general.

Another limitation on this study is the data was self-reported and participants were self-selected. Sample A participants completed a self-reported engagement survey and selectively volunteered to participate in the follow-up interviews. Once contacted to participate, Sample B interviewees selectively volunteered to complete the interviews with the researcher to discuss their self-reported experience with compassion. Limitations include only sampling research participants who have an interest in discussing compassion and their positive experiences with compassion in their work. The self-reported interview data may also be overly modest or immodest and therefore a limitation of the study.

Recommendations for Future Study

Based on the limitations, it is recommended that a replication of this study be done with a larger sample size. Obtaining data from very low and low engagement levels is necessary to generalize results. Obtaining data from additional nursing populations outside of patients with addiction and mental illness would aid in generalizing results to the nursing field.

Additionally, it is recommended that future study include data that is not only self-reported. Recommended future studies would also include observable data to increase objectivity. In this way, compassion must be more closely defined as it must be determined what constitutes as a compassionate act. The giver, recipient, or witness of compassion may view the same act differently, and it is recommended that future research determine how to analyze this.

Lastly, it is recommended that the researched explore further into the Utrecht Work Engagement Scale (UWES) factors: dedication, absorption, and vigor. The UWES questions can be allocated into each of the three categories, enabling compassion to be explored in relationship to each factor. Doing so may delve deeper into the potential confounding variables between engagement level and compassion.

Summary

This chapter presented a summary of the research findings. Results of the study were discussed relating to the literature review and research question. Study limitations and recommendations for future study were also described.

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Appendix A

Work Engagement Survey: Demographic Information

1. In your current job, do you work directly with patients?

- ☐ Yes
- ☐ No

If you do not work directly with patients, please close out of the survey now. Your answers will not be recorded.

2. What is your job title? _____

3. For demographic purposes only, enter your age. _____

4. For demographic purposes only, how long have you worked in nursing?

- ☐ 0-2 years
- ☐ 3-5 years
- ☐ 5-10 years
- ☐ 10-15 years
- ☐ 15+ years

Appendix B

Work Engagement Survey: Work and Well Being Survey

The following 9 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, check the “0” (zero) in the space after the statement. If you have had this feeling, indicate how often you felt it by checking the number (from 1 to 6) that best describes how frequently you feel that way.

Never 0	Almost Never 1 A few times a year or less	Rarely 2 Once a month or less	Sometimes 3 A few times a month	Often 4 Once a week	Very Often 5 A few times a week	Always 6 Every day
<hr/>						
1. At my work, I feel bursting with energy.	0	1	2	3	4	5 6
2. At my job, I feel strong and vigorous.	0	1	2	3	4	5 6
3. I am enthusiastic about my job.	0	1	2	3	4	5 6
4. My job inspires me.	0	1	2	3	4	5 6
5. When I get up in the morning, I feel like going to work.	0	1	2	3	4	5 6
6. I feel happy when I am working intensely.	0	1	2	3	4	5 6
7. I am proud of the work that I do.	0	1	2	3	4	5 6
8. I am immersed in my work.	0	1	2	3	4	5 6
9. I get carried away when I am working.	0	1	2	3	4	5 6

If you would be willing to be contacted by the researcher for additional questions, enter your name and contact information below (e-mail address or phone number). No identifying information will be shared. At no time will anyone know your identity except the researcher.

Appendix C

Invitation E-mail to Sample B Participants

Good Morning,

My name is Dana Lenz and I am a graduate student studying Organization Development at Pepperdine University. Thank you for your participation in the Work and Well-Being survey a few weeks ago. As part of that survey, you volunteered to be contacted for the second part of this study. You have been selected for a follow-up conversation regarding your personal experiences as a nurse. Your participation is voluntary.

If you are interested in participating, please review the Informed Consent below and respond to this e-mail with a few days and times (specifying your time zone) that you are available for a phone call. The amount of time required for this call will be approximately 30 minutes.

If you have questions please contact me at dana.lenz@pepperdine.edu or [631-806-2888](tel:631-806-2888).

PEPPERDINE UNIVERSITY
Graziadio School of Business and Management

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Understanding the Relationship between Compassion & Employee Engagement

You are invited to participate in a research study conducted by Dana Lenz under the supervision of Dr. Gary Mangiofico at Pepperdine University because you are a nurse currently working with patients. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends.

PURPOSE OF THE STUDY

The purpose of this study is to explore the relationship between compassion and employee engagement.

STUDY PROCEDURES

If you volunteer to participate in this study, you will be asked to complete a survey relating to employee engagement followed by an interview with the researcher to discuss your experiences in the workplace. The interview will be audio recorded to ensure all information is captured. Audio recording will only begin when your permission has been given at that time. If you do not wish to be audio recorded, detailed notes will be taken by the researcher. The amount of time required for your participation in this research study will be approximately 30 minutes.

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study include minor discomfort during the interview as you recall previous experiences in the workplace. This study may involve risks to you that are currently unforeseeable.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, you may experience a benefit through increased awareness about the research topic. There is an anticipated benefit to society as this study assists with furthering the research of the relationship between compassion and employee engagement for nurses.

CONFIDENTIALITY

The records collected for this study will be confidential as far as permitted by law. However, if required to do so by law, it may be necessary to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if disclosed any instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The data will be stored on a password protected computer in the principal investigator's place of residence. The data will be stored for three years after the study has been completed and then destroyed. The data collected will be coded and de-identified. If you volunteer to be interviewed by the researcher, your identity will be linked to your survey data and interview data. The data will be identifiable only to the researcher. Any identifiable information obtained in connection with this study will remain confidential. Your responses will be coded with a pseudonym and transcript data will be maintained separately. The audio-tapes will be destroyed once they have been transcribed.

SUSPECTED NEGLECT OR ABUSE OF CHILDREN

Under California law, the researcher(s) who may also be a mandated reporter will not maintain as confidential, information about known or reasonably suspected incidents of abuse or neglect of a child, dependent adult or elder, including, but not limited to, physical, sexual, emotional, and financial abuse or neglect. If any researcher has or is given such information, he or she is required to report this abuse to the proper authorities.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or only completing the items for which you feel comfortable.

EMERGENCY CARE AND COMPENSATION FOR INJURY

If you are injured as a direct result of research procedures you will receive medical treatment; however, you or your insurance will be responsible for the cost. Pepperdine University does not provide any monetary compensation for injury.

INVESTIGATOR'S CONTACT INFORMATION

You understand that the investigator is willing to answer any inquiries you may have concerning the research herein described. You understand that you may contact Dana Lenz at [631-806-2888](tel:631-806-2888) or dana.lenz@pepperdine.edu if you have any questions or concerns about this research. You may contact the research advisor, Gary Mangiofico, at [949-351-3700](tel:949-351-3700) or gary.mangiofico@pepperdine.edu.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500, Los Angeles, CA 90045, [310-568-5753](tel:310-568-5753) or gpsirb@pepperdine.edu.

If you are interested in participating, please respond to this e-mail with a few days and times (specifying your time zone) that you are available for a phone call. We will coordinate a time and method for communicating. I look forward to speaking with you!

Thank you for your participation,
Dana

Dana Lenz
Pepperdine University
Graziadio Business School
Master of Organization Development

Appendix D

Compassion Interview Script and Questions

Thank you for taking the time to speak with me today. My name is Dana Lenz and I am a student at Pepperdine University. As part of my graduate program, I must complete a research project.

With your permission, I would like to audio record this conversation for note-taking purposes, do you consent to me beginning the audio recording? As a reminder, the recording will not be shared with anyone.

To begin, would you please confirm your job title and workplace?

Thank you. Our study will be conducted with nurses who are currently working directly with patients. Today, I would like to talk to you about compassion and hear about your experiences.

Compassion is defined as “the awareness to the deep suffering of another and the desire to help relieve that suffering”. Examples of acts of compassion include a nurse taking time to hold a patient’s hand when they are in pain; a nurse taking time to sit with a family whose child is in surgery or bring them coffee while they wait. Another example of compassion may be a nurse who hugs another nurse who had a difficult patient interaction. Compassionate acts include even the smallest expression of awareness to someone’s suffering and the desire to relieve it.

1. To start, would you tell me about a time when you acted compassionately towards patients, families, or coworkers?
2. How many times per day would you estimate you act compassionately towards patients or coworkers?
3. What factors enable you to act compassionately?
4. What are barriers that prevent you from acting compassionately?

5. Do you witness your fellow nurses acting compassionately? How many times per day/week?
6. What energizes you at work?
7. What depletes you?
8. Can you tell me about a time when you felt especially appreciated by a patient or coworker?
9. Can you tell a story about a particular incident or patient that stands out in your mind as a time when you acted compassionately? After that incident, how did you feel about your job?
10. Is there anything else you would like to add?

Appendix E

Pepperdine University Institutional Review Board Notice of Approval



Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: September 06, 2016

Protocol Investigator Name: Dana Lenz

Protocol #: 16-07-334

Project Title: Understanding the Relationship between Compassion & Employee Engagement

School: Graziadio School of Business and Management

Dear Dana Lenz:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chair

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Appendix F

Human Subjects Training Certificate of Completion

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM) COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Dana Lenz (ID: 5072059)
- **Email:** dlenz@pepperdine.edu
- **Institution Affiliation:** Pepperdine University (ID: 1729)
- **Institution Unit:** MSOD

- **Curriculum Group:** MSOD Human Subjects Training
- **Course Learner Group:** Same as Curriculum Group
- **Stage:** Stage 1 - Basic Course

- **Report ID:** 17268276
- **Completion Date:** 09/13/2015
- **Expiration Date:** 09/12/2018
- **Minimum Passing:** 80
- **Reported Score*:** 86

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Belmont Report and CITI Course Introduction (ID: 1127)	09/13/15	3/3 (100%)
History and Ethical Principles - SBE (ID: 490)	09/13/15	4/5 (80%)
Defining Research with Human Subjects - SBE (ID: 491)	09/13/15	5/5 (100%)
Informed Consent - SBE (ID: 504)	09/13/15	5/5 (100%)
Privacy and Confidentiality - SBE (ID: 505)	09/13/15	4/5 (80%)
Internet-Based Research - SBE (ID: 510)	09/13/15	3/5 (60%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
 Email: citisupport@miami.edu
 Phone: 305-243-7970
 Web: <https://www.citiprogram.org>

Collaborative Institutional
Training Initiative
at the University of Miami